

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1603	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/19/2015
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF TULLAHOMA		STREET ADDRESS, CITY, STATE, ZIP CODE 1715 N JACKSON ST TULLAHOMA, TN 37388			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 000	Initial Comments During the Annual Licensure survey, conducted on 8/17/15-8/19/15, at Life Care Center of Tullahoma, complaint #34935 was investigated. No deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes	N 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE